LNCT
Learning Network for
Countries in Transition

Financing and Managing Immunization Programs in Decentralized Contexts

Day 2 – Programmatic Sustainability in Decentralized Contexts

April 2021

Financing and Managing Immunization Programs in Decentralized Contexts

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April 20-22

Interpretation

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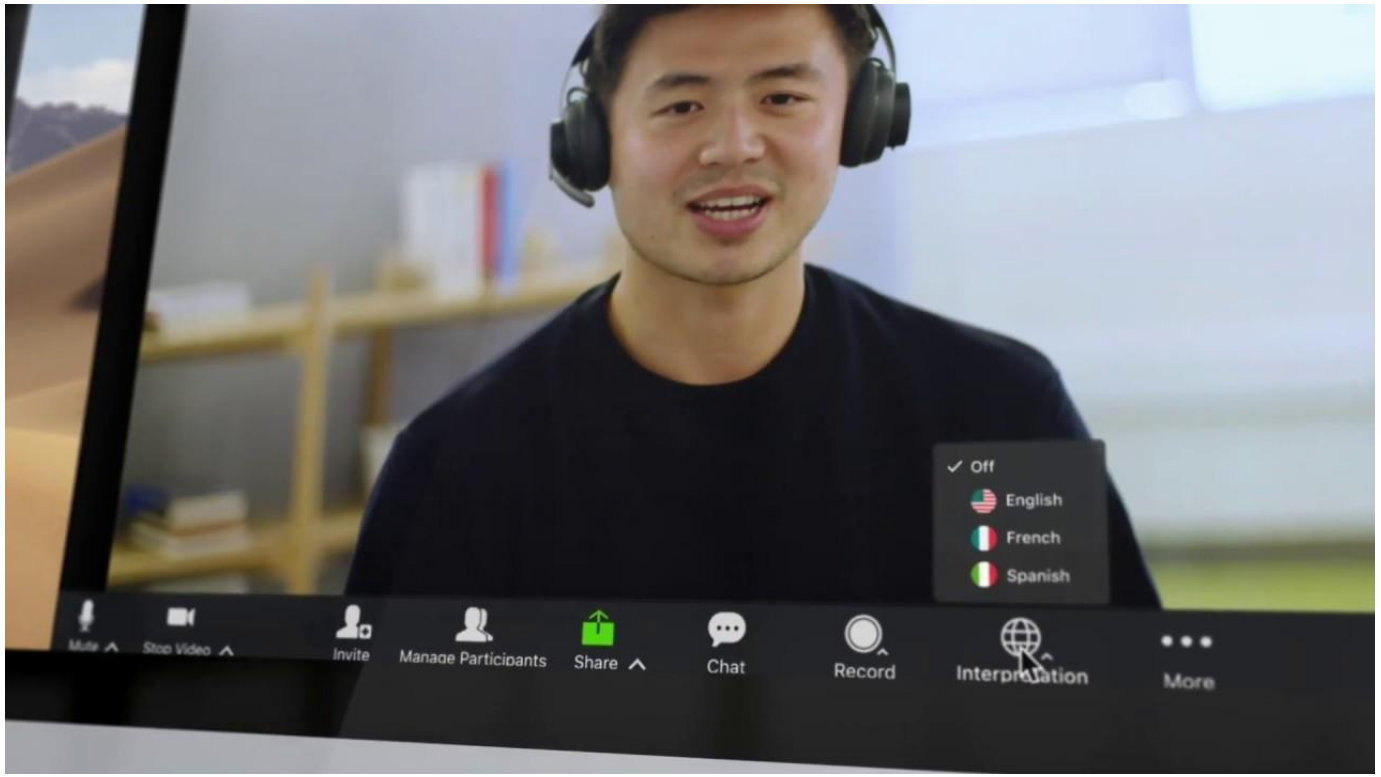

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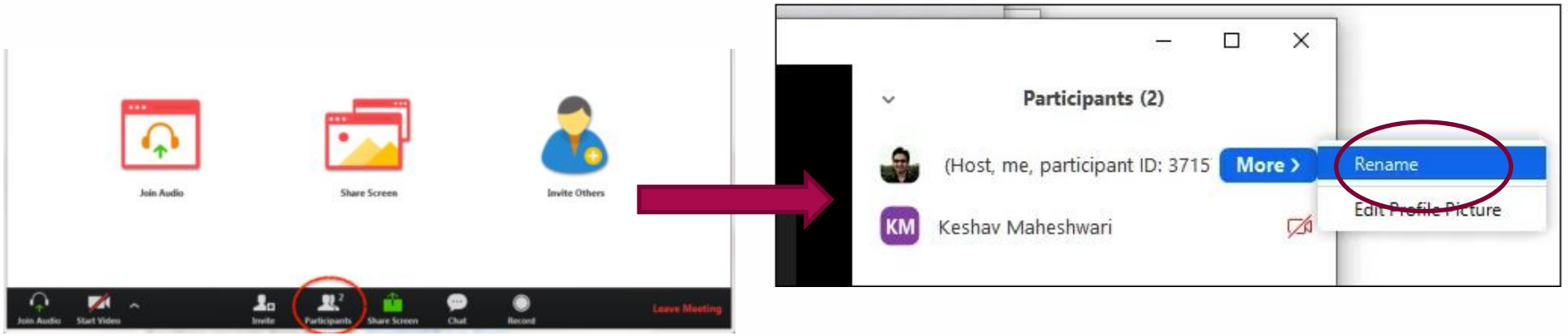

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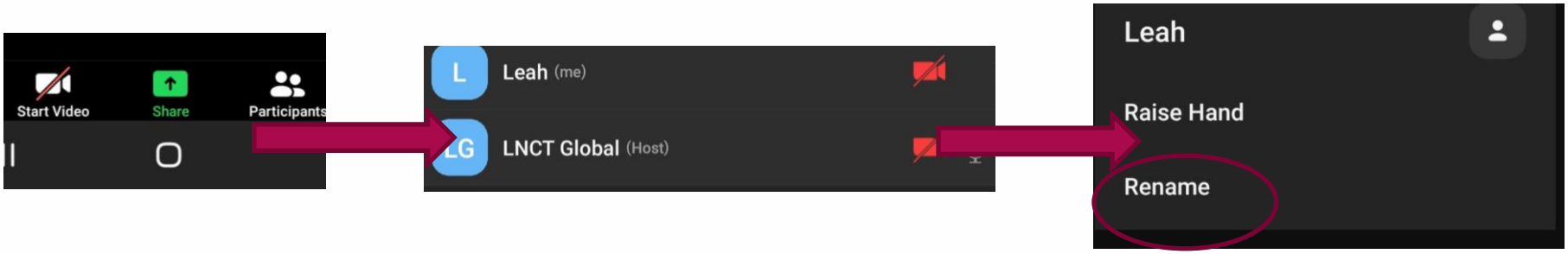

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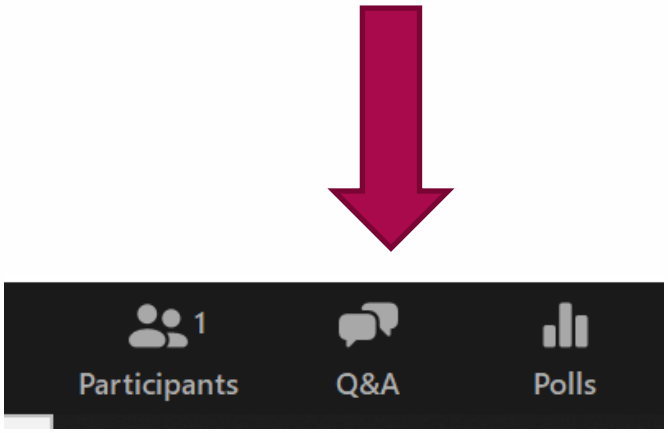

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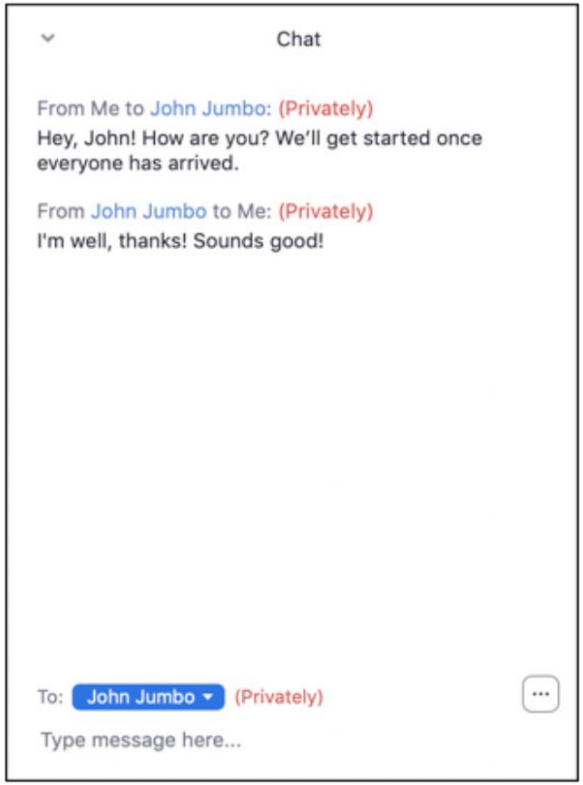

Key Takeaways from Day 1

- In general, LNCT countries feel that decentralization tends to create opportunities for immunization equity but challenges for coverage.
  - Opportunities include (e.g. NG, VT): improved access, flexibility, more rapid response to local challenges, greater local accountability
  - Challenges include (e.g. PK, NG, CG, IN): availability and continuity of financial resources, subnational implementation capacity, defining roles at various levels, coordination
  - Clear assignment of roles and responsibilities, and accountability, are key to success. Actors must have resources available to carry out the tasks assigned to them.
- LNCT countries note that the impact of Gavi transition is felt primarily financially at the subnational level
  - NG provided some examples of how to engage subnational governments in Gavi transition discussions and resource mobilization

Key Takeaways from Day 1

- COVID vaccine introduction has demonstrated a need for emergency response planning, learning about the roll out, and a more sustainable model for routine immunization
- Some LNCT countries (NG, VT) have decentralized at least some COVID roll out and financing responsibilities to the subnational level. This provides flexibility but also presents a need for leadership, guidance and capacity building.
  - PK discussed that some functions, like vaccine procurement, require some degree of centralization or coordination to function efficiently in an emergency.
  - Key COVID vaccine introduction challenges related to decentralization include:
    - Efficient and even mobilization of resources (PK, VT)
    - Coordination around planning and policy (CG, PK)
    - Subnational capacity/prioritization of hesitancy management and communications (CG, NG)
    - Availability of timely/accurate data, especially on hesitancy and VPD/AEFI surveillance (VT, IN)
    - Sustainability of human resources at subnational level (VT)
    - **Magnification of existing weaknesses in the system**

Day 2 Agenda

No.	Length	Session Title	Presenter(s)
1	10 min	**Welcome**	Leah Ewald, LNCT Network Coordinator
2	20 min	**Programmatic sustainability and health-sector decentralization: key issues for immunization programs**	Jhoney Barcarolo, Senior Advisor to the LNCT Network Coordinator
3	40 min	**Panel: Strategies for overcoming programmatic challenges**	Dr. Bakunawa Garba Bello, Nigeria Delegation, and Raihanah Ibrahim, Solina Dr. Soofia Yunus, Pakistan Delegation Cristiana Toscano, Brazil NITAG
10-minute break			
4	10 min	**Introduction to collaborative problem-solving process**	Leah Ewald, LNCT Network Coordinator
5	50 min	**Collaborative problem-solving session: Building local ownership and accountability for implementation of Nigeria's Basic Health Care Provision Fund**	Dr. Oritseweyimi Ogbe, Nigeria Delegation
6	10 min	**Evaluation Survey**	
7	5 min	**Day 2 Wrap Up**	
Day 3: Financial Sustainability in Decentralized Contexts			

Programmatic sustainability and health-sector decentralization: key issues for immunization programs

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Programmatic sustainability and health-sector decentralization: key issues for immunization programs

Jhoney Barcarolo

April 2021

Introduction and overview

In this presentation I intend to cover:

- Decentralization: recap of key concepts
- What do we mean by programmatic sustainability?
- How do programmatic sustainability and decentralization overlap?
- Key issues for program managers
- Covid-19 implications

Not covered in this presentation

- Financing and funding in decentralized settings (tomorrow)
- Use of financing instruments to foster improved health outcomes

Recap: decentralization is generally part of much broader State-wide reforms not exclusive to the health sector

- Increased emphasis since the 1970s/1980s, taking different forms:
  - Fiscal
  - Political
  - Administrative

- Decentralization affects different Ministries and programs (e.g., Education, Social Security, etc)
- Immunization programs are affected by these broader processes, but are also critical actors in shaping them – there is scope for agency and change

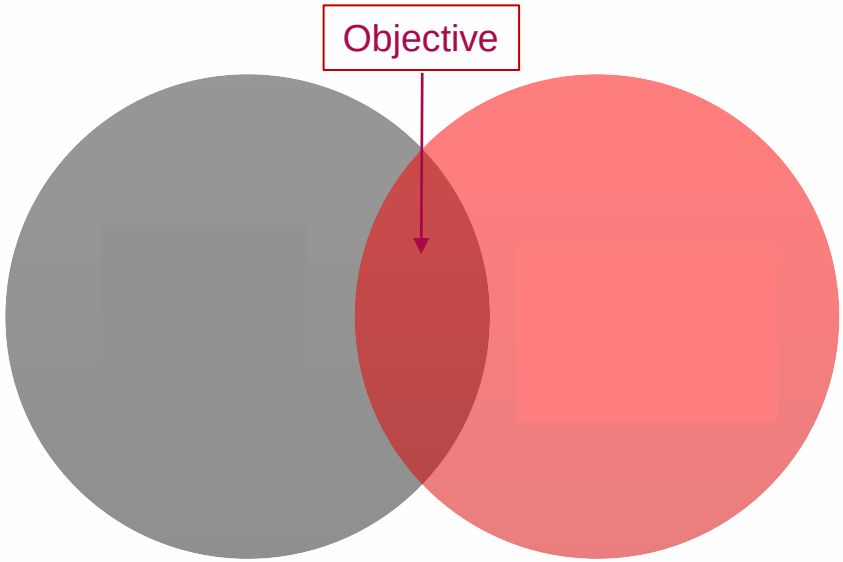
Decentralization is often used to describe a variety of situations, many of which can co-exist in the same country

- **Decentralization is commonly defined in reference to whom central actors transfer powers**

- de-concentration (to peripheral offices within the administrative structure of the central government);
- delegation (to entities or organizations outside the central government or its ministries and agencies, but which can be controlled by the central government); and
- devolution (to autonomous governments, independent of the central government);
- privatization (to private for-profit or non-profit entities using contracts) (*also referred to as 'market decentralization*')

What do we mean by programmatic sustainability?

- **Programmatic sustainability is *not only* about results**
  - A country can reach high and equitable coverage but be unable to sustain these results once donor-support ends



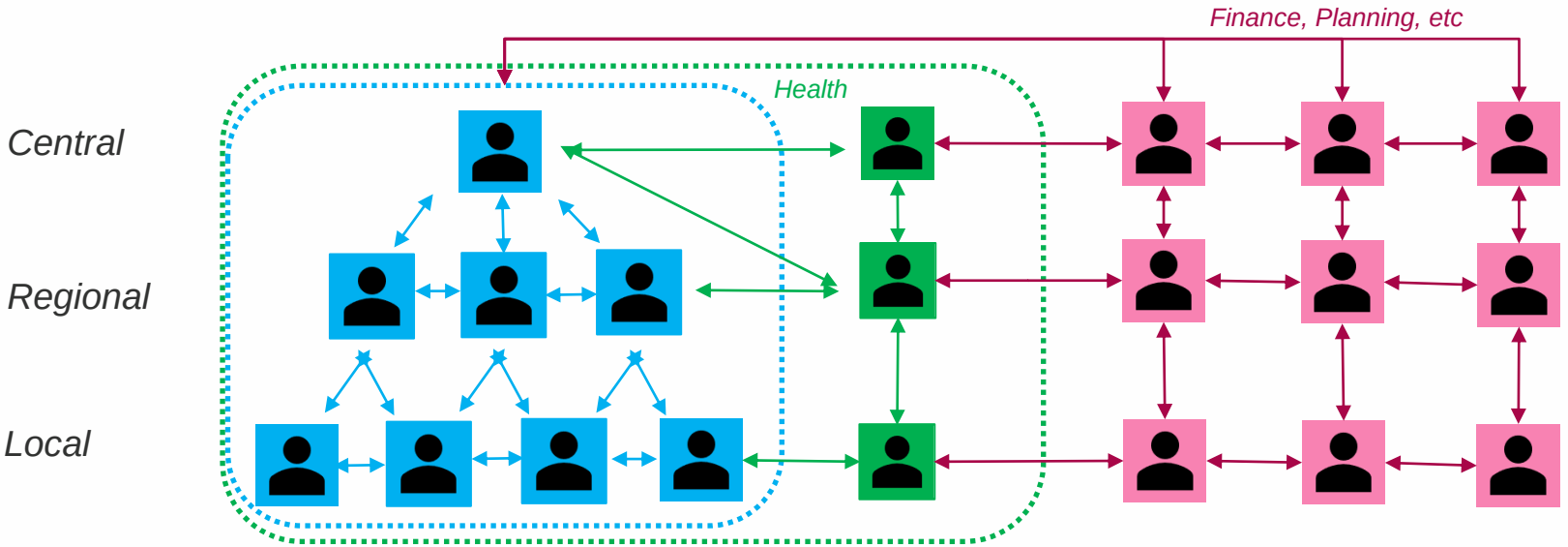
- For example, the immunization programme may be overly dependent on technical, management or political support from partners

Regardless of decentralization approach, successful and sustainable programs exhibit core programmatic capacities

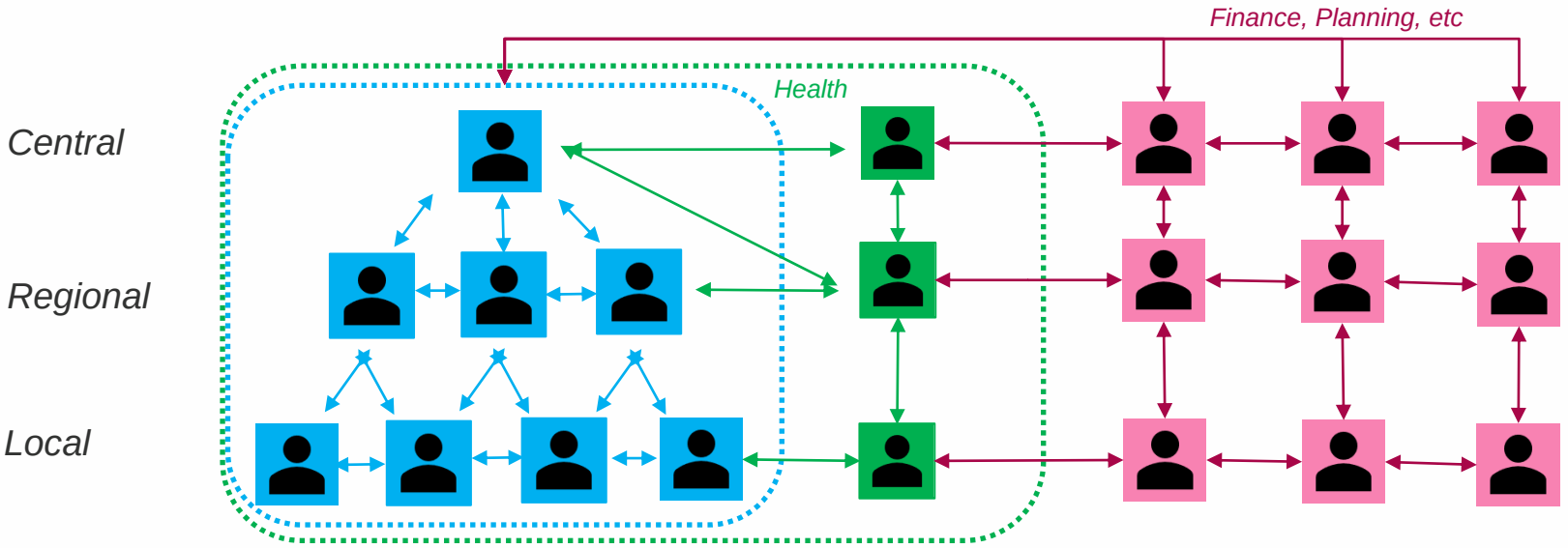
Non-exhaustive

- Programme leadership, management and coordination
  - ☑ *Capacity to oversee, manage and coordinate relevant actors, ensuring accountability and performance*
  - ☑ *Capacity to provide evidence-based technical guidance and advise the government on new vaccine introductions*
- Planning, budgeting and execution:
  - ☑ *Capacity to develop annual and medium-term immunisation plans/budgets, integrated into health plans/budgets*
  - ☑ *Capacity to execute resources allocated to fund annual immunisation plans*
- Procurement and supply chain
  - ☑ *Capacity to procure vaccines at appropriate prices*
  - ☑ *Capacity to ensure availability of products and commodities at all levels*
- Demand:
  - ☑ *Capacity for crisis management and communication on the value of vaccines*
- Data:
  - ☑ *Capacity to generate high-quality data on coverage, equity, VPD surveillance with laboratory testing and AEFI monitoring*
- Service delivery:
  - ☑ *Capacity to deliver quality immunization services equitably and at scale*

How does decentralization affect immunization programs?



How does decentralization affect immunization programs?



- **Defining roles and responsibilities is critical to ensure efficiency, performance and accountability**
  - Leadership no longer means command: less control, more influencing and persuasion
  - Leverage knowledge, experience and intelligence from the field
  - Leadership within immunization but also across the health sector and beyond

Programmatic R&Rs are usually split to reflect each level's comparative advantages and position within the system

Illustrative examples

	Planning	***Immunization policy***	***Vax Procurement***
Central level	• *Macro/long-term strategic planning* • *System-wide goal setting*	• *Lead policy design* • *Consult relevant stakeholders at different levels to assess feasibility, acceptability, etc* • *Provide technical support*	• *Product Selection and specification* • *Final quantification* • *Selection of suppliers* • *Adjudication of tender* • *Financing and payment*
Regional level	• *Ensure consistency between micro-plans and annual plans* • *Technical support, supervision and quality control*	• *Implement/support implementation* • *Identify gaps* • *Provide feedback* • *Identify best practices*	• *Provide input into implementation-related aspects of product selection* • *Support aggregation and validation of needs*
Local Level	• *Micro-planning*	• *Implement* • *Identify gaps* • *Provide feedback* • *Identify best practices*	• *Provide input into implementation-related aspects of product selection* • *Quantification of needs*

Why is the issue of R&R so important for programmatic sustainability in decentralized settings?

- **Unless it is clear who must do what and when, it is difficult to: (i) ensure accountability, (ii) promote timely decision-making and (iii) understand which bits of the system need strengthening**

  - Did strategy X failed because, e.g.,
    - People failed to do what they were supposed to?
    - Political reasons?
    - It wasn't clear who should execute it?
    - It wasn't clear who should finance it?
    - It wasn't clear who should take decisions?
    - R&R were clear but there were financial constraints?

These are not new issues, but they are increasingly being recognized as important bottlenecks to be addressed (1/2)

"Understanding Internal Accountability in Nigeria's Routine Immunisation System: Perspectives from Government Officials at the National, State, and Local Levels" (2016)

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Int J Health Policy Manag 2017, 6(x), 1–10
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IJHPM International Journal of Health Policy and Management

Original Article

Understanding Internal Accountability in Nigeria's Routine Immunization System: Perspectives From Government Officials at the National, State, and Local Levels

Daniel J. Erchick[1*], Asha S. George[1,2], Chukwunonso Umeh[3], Chizoba Wonodi[4]

Abstract

Background: Routine immunization coverage in Nigeria has remained low, and studies have identified a lack of accountability as a barrier to high performance in the immunization system. Accountability lies at the heart of various health systems strengthening efforts recently launched in Nigeria, including those related to immunization. Our aim was to understand the views of health officials on the accountability challenges hindering immunization service delivery at various levels of government.

Methods: A semi-structured questionnaire was used to interview immunization and primary healthcare (PHC) officials from national, state, local, and health facility levels in Niger State in north central Nigeria. Individuals were selected to represent a range of roles and responsibilities in the immunization system. The questionnaire explored concepts related to internal accountability using a framework that organizes accountability into three axes based upon how they drive change in the health system.

Results: Respondents highlighted accountability challenges across multiple components of the immunization system, including vaccine availability, financing, logistics, human resources, and data management. A major focus was the lack of clear roles and responsibilities both within institutions and between levels of government. Delays in funding, especially at lower levels of government, disrupted service delivery. Supervision occurred less frequently than necessary, and the limited decision space of managers prevented problems from being resolved. Motivation was affected by the inability of officials to fulfill their responsibilities. Officials posited numerous suggestions to improve accountability, including clarifying roles and responsibilities, ensuring timely release of funding, and formalizing processes for supervision, problem solving, and data reporting.

Conclusion: Weak accountability presents a significant barrier to performance of the routine immunization system and high immunization coverage in Nigeria. As one stakeholder in ensuring the performance of health systems, routine immunization officials reveal critical areas that need to be prioritized if emerging interventions to improve accountability in routine immunization are to have an effect.

Keywords: Vaccines, Immunization, Health Systems, Accountability, Nigeria

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Received: 28 May 2016
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Results: Respondents highlighted accountability challenges across multiple components of the immunization system, including vaccine availability, financing, logistics, human resources, and data management. A major focus was the lack of clear roles and responsibilities both within institutions and between levels of government. Delays in funding, especially at lower levels of government, disrupted service delivery. Supervision occurred less frequently than necessary, and the limited decision space of managers prevented problems from being resolved. Motivation was affected by the inability of officials to fulfill their responsibilities. Officials posited numerous suggestions to improve accountability, including clarifying roles and responsibilities, ensuring timely release of funding, and formalizing processes for supervision, problem solving, and data reporting.

These are not new issues, but they are increasingly being recognized as important bottlenecks to be addressed (2/2)

"Cote d'Ivoire: Strategic Plan for Community Health 2017-2021"

Défi n°8 : Implication des collectivités locales

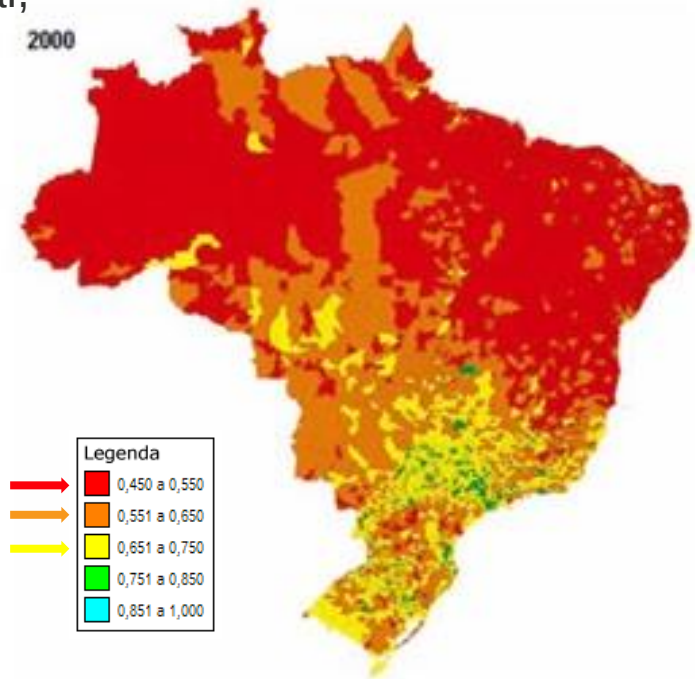
Dans le cadre du renforcement de la décentralisation et du transfert des domaines de compétences devant l'accompagner, il convient de préciser, de renforcer et d'accompagner les collectivités locales pour qu'elles jouent leur rôle dans la coordination, le financement et le suivi de la santé communautaire. Ainsi, leurs responsabilités exactes en termes de capacités techniques de gestion de la santé communautaire, leurs liens avec les districts et les régions sanitaires méritent d'être clarifiés.

Transition, decentralization and programmatic sustainability in practice: an example from Brazil

At the macro-level: highly unequal distribution of income, with large socioeconomic disparities

- Federal Republic, 3 levels of government (Federal, 26 States and ~5500 Municipalities)
- Population (2003): 181 million
- GNI per capita (2003): US$ 2,980
- Decentralized National Health System, with financing and technical responsibilities split across three levels
- The issue: Highly successful National HIV/AIDS Program perceived as unsustainable: some functions were centralized, verticalized, and partially off-budget (e.g., management, M&E, outreach activities) and implemented through project lending from the WB

Human Development Index in Brazil, by municipalities, 2000



Comparators: Canada: 0.901, Italy: 0.838, Georgia: 0.690, Brazil: 0.685, Moldova: 0.643, India: 0.495, Madagascar: 0.462

Transitioning and programmatic sustainability in the Brazilian HIV program (2003-2010)

Objective: mainstream centralized/verticalized functions of the HIV Programme into the National Health System

- Programmatic Approach:

i. Negotiate and agree on R&R

ii. Assess technical and financial risks and gaps of States (and key municipalities)

iii. Central level to provide targeted technical support and capacity building, with continued monitoring and supervision

iv. Intensified political advocacy

v. Robust M&E system, with constant course-correction

Classification of Brazilian States by level of risk, 2003

	FINANCIAL RISK	TECHNICAL RISK
LOW	Para, Amapa, Roraima, Piaui, Bahia, Mato Grosso, Espirito Santo, Sao Paulo, Santa Catarina	Sao Paulo, Rio Grande do Sul, Santa Catarina
MEDIUM	Acre,Tocantins, Sergipe, Alagoas, Maranhao, Paraiba, Pernambuco, Ceara, Goias, Mato Grosso do Sul	Acre, Amapa, Para, Alagoas, Bahia, Paraiba, Pernambuco, Piaui, Sergipe, Maranhao, Goias, Mato Grosso
HIGH	Rondonia, Amozonas, Rio Grande do Norte, Distrito Federal, Minas Gerais, Rio de Janeiro, Rio Grande do Sul	Amazonas, Rondonia, Roraima,Tocantins, Rio Grande do Norte, Distrito Federal

- High- and medium-risk States received direct support from the central level on a quarterly basis until capacity to implement improved (over five years).

Note: Technical risk was defined on a state's capability in terms of possessing the necessary staffing, MIS systems for patient follow-up functioning, NGO partnerships established, prevention activities with high-risk groups under way, and specific activities addressing PMTCT.
Source: Project Appraisal Document, AIDS & STD Control III Project, June 2003

Programmatic perils of decentralization: some possible issues and mitigation strategies (1/2)

Issue	*Example of mitigation strategies*
▪ Loss of efficiency and/or economies of scale when functions such as procurement are transferred to subnational governments	• *Re-centralize procurement of certain commodities to ensure lower prices and maintain quality*
▪ Weak administrative and/or technical capacity at lower levels	• *Implement step-wise transfer of responsibilities* • *Identify gaps and implement staffing/capacity building plan*
▪ Transfer of administrative responsibilities without adequate resources to effectively execute	• *Understand whether this is Immunisation-specific or structural* • *Identify and implement suitable legislative and financing changes*

Programmatic perils of decentralization: some possible issues and mitigation strategies (2/2)

Issue	*Example of mitigation strategies*
▪ Inequitable distribution of resources	• *Implement or review resource allocation formulas* • *Develop tailored advocacy strategies aimed at the relevant decision makers*
▪ Difficulty coordinating implementation of national policies across subnational entities	• *Strengthen coordination and leadership capacities* • *Clarify respective mandates* • *Legal recourse*
▪ Trust and coordination with private sector not transferring to local levels	• *Consult stakeholders to understand underlying reasons* • *Implement regulatory framework and capacity building* • *Share best practices and establish confidence-building measures*

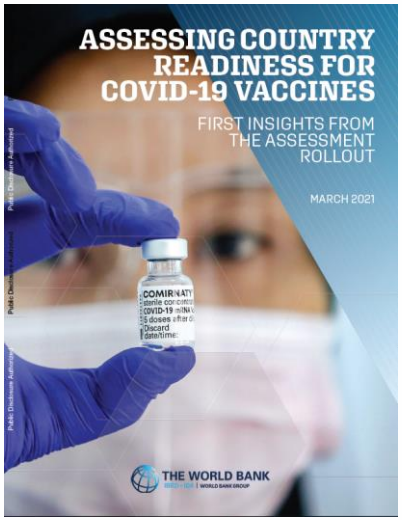
Covid, decentralization and sustainability: some interim observations (1/2)

Covid has un-masked programmatic vulnerabilities worldwide

1. Covid has provided further evidence how epidemics may jeopardize the sustainability not only of immunization but of whole economic and social systems

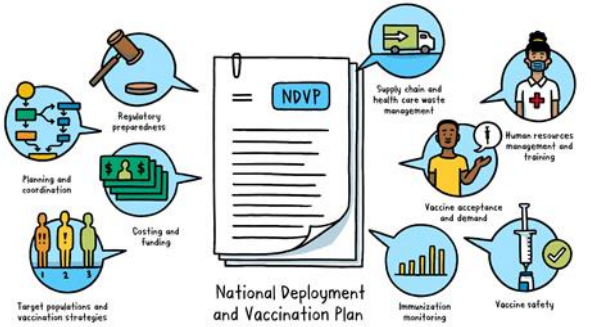
2. Covid has exposed significant programmatic weakness at multiple levels, e.g.,
   - *Emergency preparedness*: lack of clear R&R, poor coordination, inexistence of crisis management protocols, insufficient training and awareness
   - *General health system*: inadequate surveillance and information systems, lack of health personnel, hospital capacity
   - *EPI* : inadequate communication strategies to address rumors and fake news related to immunisation, vaccine hesitancy (and AEFI systems not yet tested in most of the world)

Covid, decentralization and sustainability: some interim observations (2/2)



3. Few countries are using the opportunity provided by the imminent deployment of COVID-19 vaccines to strengthen health systems and find long-lasting solutions for similar future challenges

4. Existence of well-functioning child immunization national delivery systems is not a strong predictor of country readiness to deliver COVID-19 vaccines – particularly given differences in target population, the scale and speed required – but it is the basis



Key take-away messages

1. Decentralization is generally a trend beyond EPI control, but **immunization program managers can help shape it** and leverage it to enhance the program's outreach, resilience and impact

2. **Clarity about programmatic roles and responsibilities** is critical to ensure timely decision making, promote mutual accountability and inform dialogue on financial responsibilities (and possible gaps)

3. **A high-capacity immunization programme remains a key aspect of epidemic preparedness** – but covid has shown how much more remains to be done

4. **Immunization is high on the agenda of decision-makers:** leverage opportunity to mobilize (domestic and external) resources, strengthen critical country capacities, and "build (back) better"

Thank you

Panel: Strategies for overcoming programmatic challenges

Experiences from Nigeria, Pakistan, and Brazil

Building subnational immunization program performance through Peer Learning Exchanges

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Building subnational immunization program performance through Peer Learning Exchanges

Nigeria

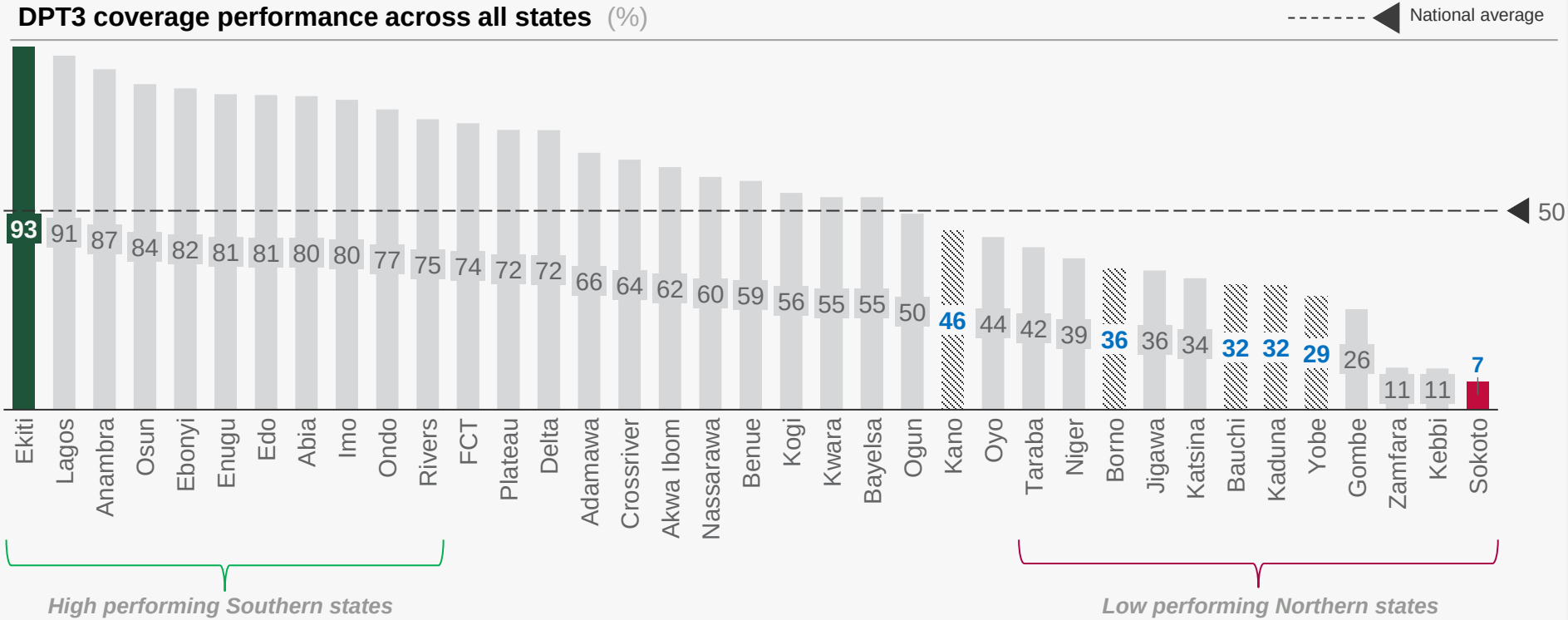
April 2021

Dr. Bakunawa Garba Bello, Nigeria Delegation
Raihanah Ibrahim, Solina

Background: Immunization performance and financing inequity

- Nigeria's constitution establishes a highly **decentralized federal system** with 37 states comprising of 774 local government areas
- The Federal government is majorly responsible for policy development, vaccine procurement, technical support, and tertiary care while the State and local governments are responsible for lower levels of care, routine immunization infrastructure and logistics
- States exercise broad budgetary authority, with the majority of their budgets coming from unconditional transfers from the federal government
- A major concern for Nigeria's immunization program is the large disparity in immunization spending, system performance and coverage between states, with states in the South tending to fare better than those in the North

Southern Nigerian states have better immunization coverage than those in the north



- Low coverage in the lower performing states has been linked to demand side issues and weaknesses in program management systems and capacity in areas such as leadership and governance, logistics and planning, service delivery and supervision
- Health financing is also a major challenge with subnational health expenditure accounting for an average of 2.2% of the total expenditure though it varies from 7.1% in the South (Imo) to 0.7% in the North (Zamfara)
- Six Northern states (Bauchi, Borno, Kaduna, Kano, Sokoto, and Yobe) have ongoing RI strengthening MoU partnerships with BMGF, ADF and other core donors to tactically and innovatively address these challenges

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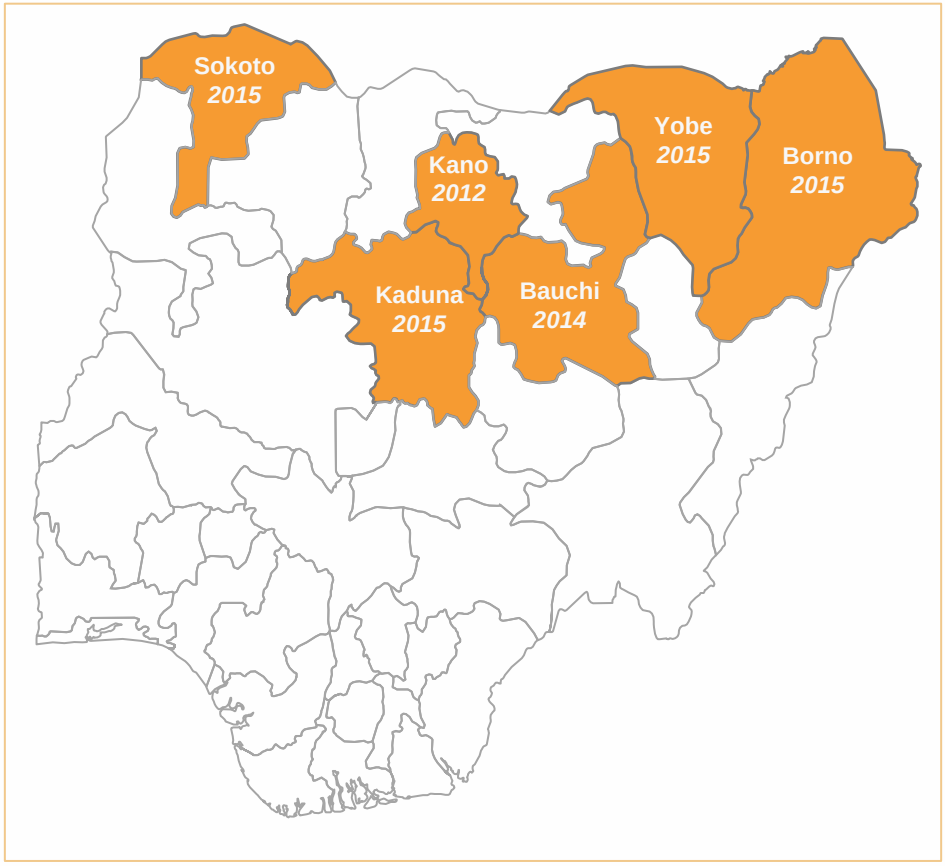
Source: NDHS 2017 survey

Context: The MoU approach for RI systems strengthening



Problem

Low Immunization coverage rates due to

- Inadequate funding and oversight
- Poor access to quality immunization services
- Weak community demand for immunization

The MoU Solution

- Set up innovative funding and coordination mechanisms
- Channel secured funds into strengthening RI systems across key PHC building blocks
- Build institutional & personnel capacity

Principles

State ownership || Transparency || Sustainability

*SCIDaR delivers TA to the 6 state PHC agencies to improve routine immunization systems and overall coverage. Specifically; we **provide technical program management support**, innovative data-driven **thought leadership** and **problem solving** (through direct TA and learning exchanges) and **on-the-job capacity transfer** to government program managers*

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SCIDaR convenes immunization managers from the states routinely to jointly address common program challenges

Focus	Details
What	▪ Convening of key immunization stakeholders to jointly resolve challenges on the immunization program on a particular topic of mutual interest expressed by the MoU states ▪ During these meetings, ○ The better-performing and/or more advanced state leads discussions on the chosen topic ○ SCIDaR facilitates problem-solving discussions with participants and jointly develop solutions and clear implementation plans with timelines for progress tracking ▪ Afterwards, SCIDaR consultants embedded in the SPHCDAs provide direct TA for overall coordination of the entire process and on-the-job mentoring to the program officers to successfully implement all resolutions
Who	▪ State Primary Health Care Board/Agency Leadership, and Immunization Managers/Officers ▪ Representatives from the MoU parties and other state-level Implementing Partners ▪ Representatives from NPHCDA
When	▪ Once or twice a year
How	▪ On-site learning workshops/meetings ▪ Learning tours and direct observation between states

*These convenings **build on the platform of the MoU partnership** and its established basket-funding arrangement, and systems strengthening efforts*

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Source: NDHS 2017 survey

Peer learning exchange : Results

	Vaccine Supply Chain	Financial Management	Demand Generation
Problem	○ Frequent vaccine stockouts due to supply chain bottlenecks	○ Absence of accountability mechanisms to adequately account for funds used	○ Low immunization coverage as a result of poor immunization demand
Resolution	○ Revamp vaccine logistics to **a direct vaccine delivery system** to service delivery points	○ Institutionalize a financial management system (with direct electronic disbursements, retirements and validation, and audits)	○ Implement a community-led name-based community engagement strategy for identification and tracking of eligible children
Gains	○ Improved vaccine stock performance **30-50% ➡ 1-5%** *Vaccine stock out rates* ○ System has been considered for adoption and scale up in other non-MoU states	○ ⬆⬆⬆ **availability of funds** for service delivery and program operations ○ ⏩ **accountability** and transparency for program expenditures ○ The RI FM Legacy has been leveraged for other funding streams (e.g. BHCPF), and expanded to other PHC services ○ Documented and shared widely – *RI Financial Management Guide*	○ ⬆⬆ **demand for immunization** services and; ○ ⬆ **community participation** in service delivery and tracking ○ Adopted by the NPHCDA as a national strategy ○ Ongoing conversations to expand the strategy to maternal health

In some cases, these exchanges are followed by learning tours to more advanced states to directly observe implementation and acquire practical knowledge on the strategy. E.g. Bauchi to Kano on Insourcing for DVD

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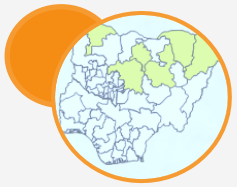
Peer Learning Exchanges: Keys to Success

Collaboratively selecting the relevant topic

– Working with the state teams to identify topics of interest and polling across states

Strategically engaging the right stakeholders

– High level decision makers involved to obtain buy-in and jointly make strategic decisions
– Partners to adequately provide TA through implementation of designed solutions
– National level stakeholders to facilitate policy-related adjustments and share lessons widely



Healthily spurring rivalry between states

– Highlighting lessons and success stories from better-performing/more advanced states to trigger healthy competition and thus provide an incentive for other states

Contextually designing practical solutions

– Use state-specific peculiarities to build implementation roadmaps that are practical and SMART
– All solutions co-created with the state implementation teams - both government and partners

Efficiently leveraging the MoU platform

– Using the existing MoU finances to resource the plans
– Building on the established system strengthening platforms

Peer Learning Exchanges: Challenges

1

Competing priorities in the state affecting the scheduling of the sessions; typically requires convening all key officers for relevant themes in the discussions

2

Slow pace of implementation of the resolutions from the exchanges due to implementation constraints at state-level

Thank you!

Aligning procurement responsibilities and financing in a decentralized context: An experience from Pakistan

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Aligning procurement responsibilities and financing in a decentralized context

An experience from Pakistan

April 2021

The 18th Amendment devolved healthcare from the federal to the provincial level

After approval of 18th amendment of the constitution, the **Ministry of Health including EPI was devolved to the provincial level**

Implementation of healthcare including EPI became a provincial subject and **all functions related to immunization shifted to the provinces**

National government became responsible for **coordination and regulation of healthcare across the country**

~32 million children are under the age of 5 in Pakistan

POPULATION

- 227.5 million (2020) (1.4 million Afghan Refugees)
- 32 million children < 5 year

GDP PER CAPITA

- US$ 1,497 in 2018-19
- US$ 1,652 in 2017-18

OUT OF POCKET EXPENDITURE

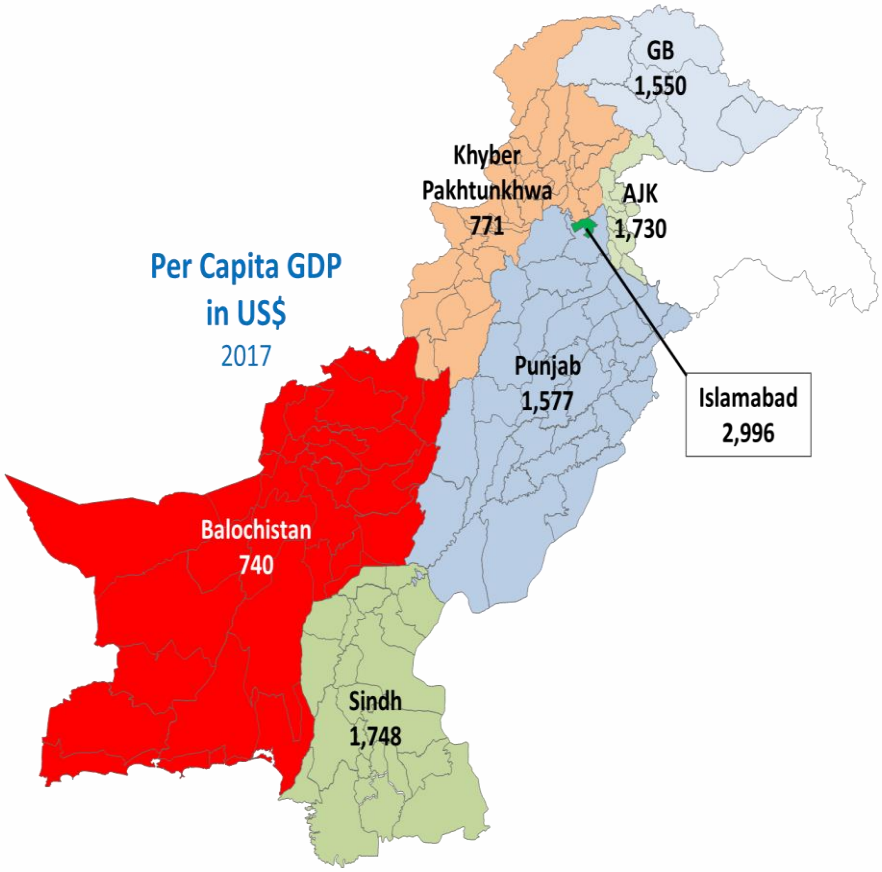
- ~57.6% of total health expenditure

SPENDING ON HEALTH

- Per capita health expenditure: US$ 45
- Per capita government health expenditure: US$ 15.8

IMMUNIZATION

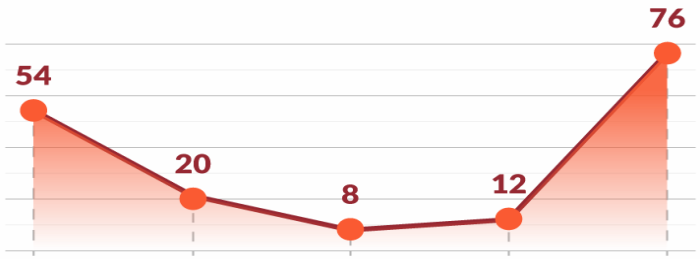
- Low immunisation coverage
- One of 2 countries where Polio is endemic



Source: Situation Analysis Report 2020 & National Health Account 2015-16

Immunization in Pakistan can be understood through 4 areas

1 INCREASE IN POLIO



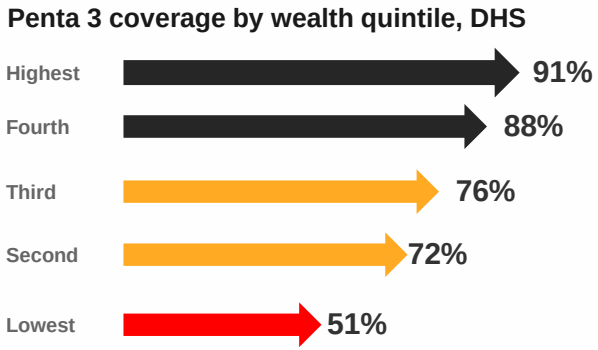
2 PARTIALLY IMMUNIZED

Partially immunized (30.7%)

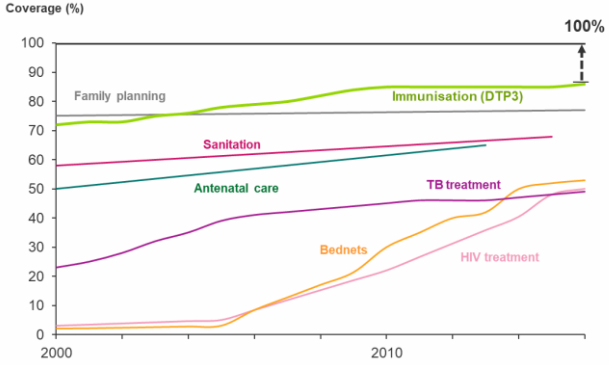
Zero dose (3.7%), 225,000 children each year

Fully immunized (65.6%)

3 INEQUITY REMAINS A CHALLENGE[1]



4 HIGHEST AMONG HEALTH INTERVENTIONS[2]



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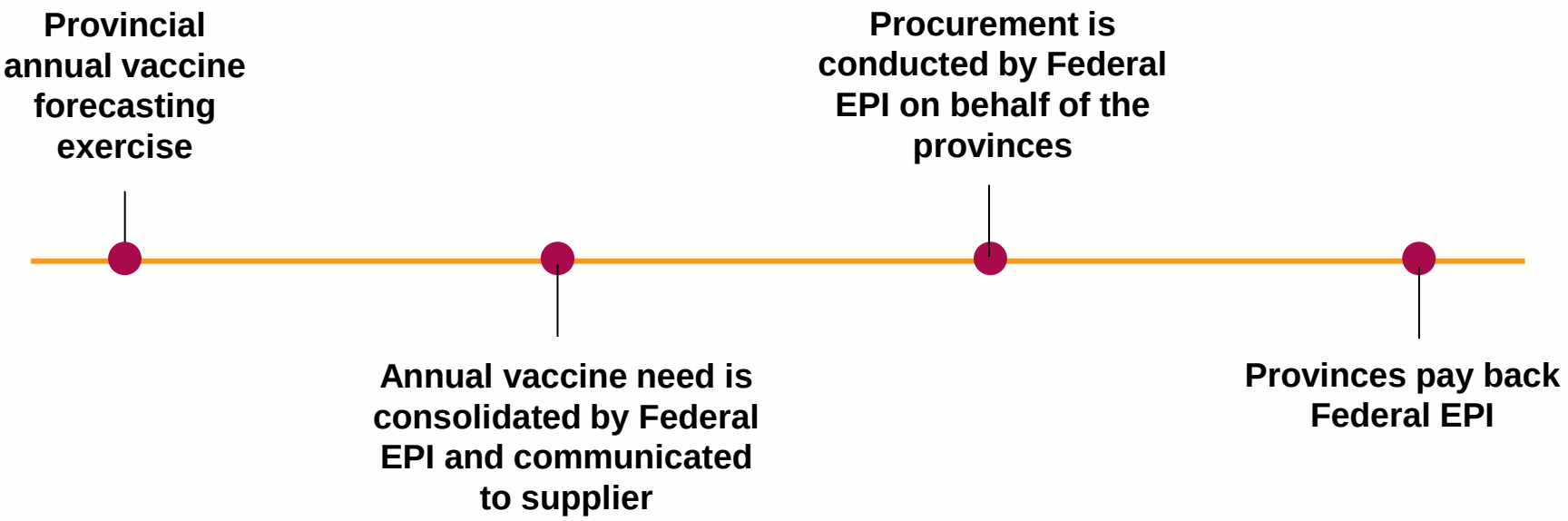
[1]National Strategy to increase immunization coverage 2019, [2]UHC Global monitoring report

Provinces agreed to the pool procurement of vaccines to achieve economies of scale

- Immediately following decentralization, **provinces were responsible for vaccine procurement,** funds for the procurement of vaccine were shifted to provinces through NFC Award
- Considering the **efficiency and economies of scale**, the Federal government (Federal EPI M/o NHSR&C) **developed a National PC-1 (2015-16 to 2019-20) in consensus with provinces**
- **A pool procurement system was agreed by the provinces, and Federal EPI was given the responsibility to procure vaccines** and vaccine related items, such as cold chain equipment on behalf of provinces
- It was also agreed that **funds for procurement of vaccines would be transferred by the provincial government to Federal Government** according to the share of provinces in the PC-1
- **Federal EPI was also given the responsibility to do procurement, custom clearance, storage at national level** and further supply to the provincial levels according to the share of the provinces when needed.

Vaccines are now procured through a pool procurement mechanism

Pool procurement mechanism



The pool procurement system has several benefits

- As a result of pool procurement system, **EPI Pakistan fulfilled all GAVI Co-Financing Obligations in timely manner**
- **Traditional vaccines were procured as per allocation in PC-1** for each financial year from 2015-16 to 2019-20
- **EPI Pakistan maintained sufficient stock of vaccine at all levels for GAVI** as well as traditional vaccines (No major stock out in last five years)
- In addition to that pool procurement system also benefited in **provision of cold chain equipment at district and health facility levels through CCEOP** and at National and Provincial level through Non CCEOP
- The pool procurement funds were used exactly as per the allocation, and not for any other purpose
- **Pool Procurement system involve procurement of traditional vaccines through government tender**, whilst **Polio, non-Polio and new vaccines are procured through UNICEF**. If government tender is non-responsive, procurement is done through UNICEF

EPI has learned multiple lessons through this process

- **Forecasting of vaccine improved considering the stock levels up to third tiers** and correct denominator in consultation with provinces
- It was a successful experience in **providing uninterrupted supply of potent vaccines and devices** resulting in fulfillment of GAVI Co Financing obligation in timely manner.
- **Economies of scale and best prices**, timely supplies and timely payments
- **Adequate supply of vaccine** according to the share of the provinces
- **Equity in terms of vaccine supply chain management** and cold chain equipment considering the share of provinces as per the population and access
- Immunization Supply Chain System design was an opportunity to **improve the infrastructure, risk mitigation for vaccine stock distribution** through appropriate supply chain routes at all levels
- **Improved coordination for timely vaccine procurement**, vaccine management and deployment of cold chain equipment between Federal EPI, Provinces and technical partners
- National Immunization Support Project (NISP) an innovative financing instruments, **successful implementation of DLI 4** regarding supply chain management which includes pool procurement system as well

The country is faced with few major challenges

1. Sometimes **delay in transfer of funds from provinces resulted in delayed or last moment procurement which put country at risk of GAVI default**

2. Pool procurement system was setup for RI vaccines, in case of outbreak specially Measles outbreaks the National level faced **challenges to supply sufficient stocks for case response or campaigns in addition to RI stock**

3. **Non-responsive of Government tender**, due to local market constraints

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Thank you!

Questions and answers

Lessons learned from COVID-19 vaccine roll-out in Brazil, 2021

April 21st, 2021

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Lessons learned from COVID-19 vaccine roll-out in Brazil, 2021

Virtual Workshop on Financing and Managing Immunization Programs in Descentralized Contexts

Dr Cristiana Toscano, MD, PhD

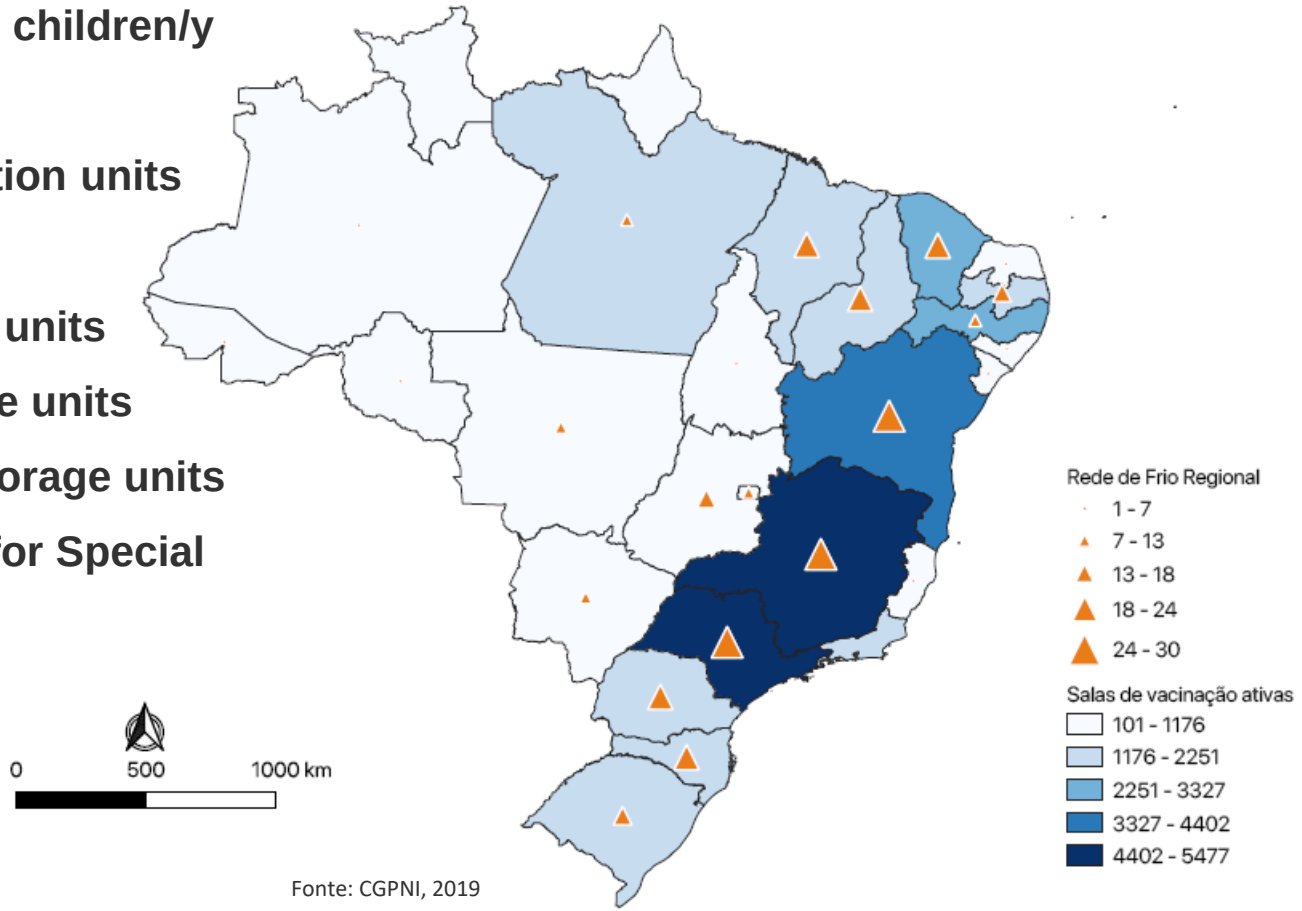
Member of the PAHO Regional Technical Advisory Group of experts (TAG) for vaccines
Member of the WHO SAGE working group on COVID-19 vaccines

Outline

- National Immunization Programme in Brazil
- Descentralized Healthcare System
  - EPI in descentralized systems
- Emergency situation: COVID-19 vaccine rolout
- Lessons learned

Brazilian EPI

- Established in 1973
- Birth cohort = 3million children/y
- 5,570 municipalities
- ~36 thousand vaccination units
- Cold chain structure
  - Regional Storage units
  - State level storage units
  - Municipal level storage units
- 30 Reference centers for Special Biologicals



Fonte: CGPNI, 2019

Brazil's Descentralized Healthcare System
SUS

- 1988 Constitution – National Unified Healthcare System (SUS)
- Free of charge, universal access, integral and equity of care
- Operation defined by Organic Health Law (*Lei nº 8.080*), of 1990
  - Descentralized System
  - Coordination at each level of health management
  - Shared responsibilities by the Federal, State and Municipal levels
    - Ministry of Health
    - Council of State Health Departments
    - Council of Municipal Health Departments
- National leadership and coordination of National EPI
  - State Level Immunization Coordinators

EPI Activities by level of program management

- Federal:
  - Vaccine procurement and purchase
  - Vaccine quality control
  - Vaccination Norms and strategies
  - Information Systems
  - Cold chain structure
  - Vaccine distribution
  - Planning and Coordination
  - Supervision
  - Capacity Building
  - Social communication
  - Adverse events surveillance and monitoring

- Municipal:
  - Vaccine distribution
  - Cold chain maintenance
  - Planning and Coordination
  - Supervision
  - Capacity Building
  - Social communication
  - Adverse events surveillance

- State level:
  - Vaccine distribution
  - Cold chain maintenance
  - Planning and Coordination
  - Supervision
  - Capacity Building
  - Social communication
  - Adverse events surveillance

- Vaccination Unit:
  - Administration of vaccines
  - Cold chain maintenance
  - Training and Capacity Building
  - Mobilization
  - Investigation of reported adverse events

National level Responsibilities
Leadership and coordination activities

- Planning
- Procurement/purchase
- Distribution
- Standardized technical norms and recommendations
- Social media and communication – clear and consistent
- Capacity building at all levels
- National leadership
  - Coordination and close communication with state EPIs
  - Regular meetings
  - Continuous communications to share experiences, challenges, agree on joint decisions to manage operational issues

COVID-19 Vaccine rollout in Brazil
Challenges related to descentralization

- Lack of strong leadership and coordination at national level, articulated with sub-national state level coordination
- Vaccination norms and strategies poorly developed
- Limited ability of planning vaccine rollout at local levels due to intermittent and non-steady supply of vaccine doses once rollout was initiated
- No social communication and mobilization at national level
- Lack of timely and evidence-based positioning and statements of the National EPI in response to safety signals and other concerns
- State and Municipal levels in charge of additional responsibilities
  - Vaccine procurement
  - Developing norms and defining priority vaccination groups
  - Social communication and mobilization at local level

Reasons for the underperformance of EPI in this context

- Lack of early central level engagement and support to vaccines and its acknowledgement as an essential strategy to overcome the pandemic
  - Limited access to vaccines
- Political stage between two presidential candidates (2022 elections)
  - Opposing 2 vaccines and stimulating anti vaccine movements
- Strong anti-science environment
  - Support and endorsement of non-efficacious therapies for COVID
- Delays in supplying vaccine in bulk
  - Made worse by diplomatic failure (in particular with China in India)
  - Delays in local vaccine filling resulting in inconsistent and sub-optimal vaccine availability during rollout

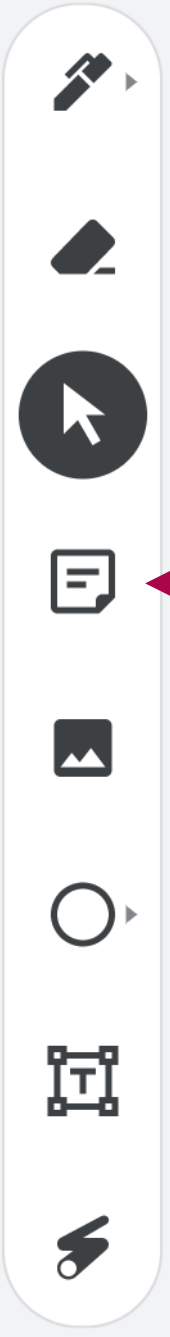
Emergency preparedness in decentralized settings
Lessons Learned from Brazil

- Importance of strong leadership at national level
- Need for continuous and sustained coordination articulated with EPI coordinators at state levels
- Need for clear and consistent messages and vigorous and timely communication strategies
- Centralized procurement and distribution is critical
- Importance of robust and centralized information systems

Thank you!

Break Activity!

- Visit the Jamboard (link in the chat)
- Go to slides 9-10
- Find time over the next couple of days (coffee breaks are good!) to indicate where responsibility for each immunization function lies in your country by placing a Post-It in the appropriate column with your country's name on it.
  - Orange = this is a challenge area for your country; green = this is a strength for your country; blue = neutral
  - For shared responsibilities, you may have to put a Post-It in both columns
  - See the examples from LNCTovia!



5-MINUTE BREAK

Collaborative problem-solving session

Instructions: Collaborative Problem Solving

- 10 minutes: The Nigeria delegation will present on a decentralization-related challenge that their immunization program faces. They will conclude by posing three discussion questions to the audience.
- 30 minutes: Nigeria will mute themselves while a LNCT facilitator leads a discussion on Nigeria's challenge statement and discussion session.
- 10 minutes: Nigeria reflects on key takeaways from the discussion.

Goal: Generate some new ideas to address Nigeria's challenge, and perhaps apply them in your own country.

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Building local ownership and accountability for implementation of Nigeria's Basic Health Care Provision Fund (BHCPF)

Collaborative problem-solving discussion

LNCT Decentralization Virtual Workshop
April 2021

Dr. Oritseweyimi Ogbe, Chief Medical Officer, Health Financing Program and Lead BHCPF NPHCDA Gateway

Background: Health system financing challenges in Nigeria

- Nigeria has one of the highest rates of out-of-pocket spending at ~77% *(NHA 2017)* and one of the lowest rates of health insurance coverage in the world <10% *(NHIS public and private insurance)*
- Wide variation in health spending between States, with combined subnational health expenditure accounting for less than 10% of total health expenditure (states 6.9%; LGA 1.2%)
- Spending on PHC is approximated at less than 10% (inadequate to fund HRH and WMHCP in most states)
- Weak budgetary commitment *(0.7% GDP and 6.6% against 15% Abuja Declaration)*; coupled with supply-side issues, these financing challenges make basic care inaccessible for many Nigerians
- Immunization coverage varies widely between states, from 7% in Sokoto to 93% in Ekiti

Background: Nigeria's Basic Health Care Provision Fund

- Primary Health Care Under One Roof Initiative aims to address management inefficiencies for primary health care, including access, quality, infrastructure, and commodity issues.
- The Basic Health Care Provision Fund (BHCPF) aims to address financial barriers to access for the poor and vulnerable through catalytic funding
  - Established by National Health Act of 2014 ear marks at least 1% of Consolidated Federal Revenue for the Fund to make supply and demand-side investments for PHC
  - States expected to *contribute 25% of Fund*
  - Initial funding is catalytic, with anticipated increased funding at sub-national level and from non-state actors over time
  - Includes:
    - DFF to fund infrastructure, human resource strengthening, and commodities
    - Insurance coverage *for the most vulnerable* to access a Basic Minimum Package of Health Services, including immunization

Implementing the Basic Health Care Provision Fund: Challenges

- Implementation of BHCPF has been delayed at the subnational level, mainly due to slow release of required funding for 'take-off' activities *(level of implementation: 82% states, 51% targeted PHCs)*
- Challenges for implementation at the subnation level include:
  - Reinforcing ownership and leadership over implementation at the State and LGA levels
  - Lack of budgetary commitment at State and LGA levels, aggravated by funding displacement
  - Political interference in planning, implementation and enforcement
  - Poor coordination, planning and structure governance mechanisms between and within levels of government leading to role conflict and accountability gaps
  - Challenges to central planning in efficiently adapting implementation plans to different local contexts
  - Lack of sufficient mechanisms and capacity for effective monitoring progress and financial tracking
  - Current funding commitments, if met, would still be insufficient to fully scale up BHCPF (*especially for health insurance*) – additional funding is necessary.

Problem Statement

Financing and implementation of Nigeria's Basic Health Care Provision Fund, which aims to improve effective access to primary health care – including immunization – for the poor and vulnerable, is hindered by insufficient financial resources, weak ownership and accountability mechanisms at the local level.

What's been done so far?

- Increasing facility ownership through greater financial and decision autonomy:
  - Decentralized facility financing aims to allow funds to flow directly to facility level and allow facilities autonomy over expenditure decisions
  - Facilities provided with a block revolving fund, which could be used to procure commodities and earn from insurance providing an autonomous source of funding/revenue
  - Efforts at expanding the Social Health Insurance Schemes at community level and advocacy for local private/non-governmental organizations to establish community-based social health insurance schemes as a locally-controlled source of revenue.
- Co-ownership and management with Ward Development Committees, comprised of various segments of the community and having authority to fundraise, identify problems, and establish action plans.
- Implementation score card to strengthen PHCUOR and intensifying tracking of the BHCPF.

Monitoring Progress

- PHCUOR Score Card consist of 9 pillars:
  - Functionality of governance structure *(LGHA)*, legislation and funding mechanisms for PHC through the State PHC Agencies
  - Infrastructure and equipment sufficiency at state and PHC levels,
  - Availability and delivery of the WMHCP of services; including use of SOP and guidelines at state and PHC levels.
- BHCPF Monitoring in 2 Phases:
  - Take-off score card: establishment of financial structure, HR capacity, and establishing basis for future evaluation
  - Implementation monitoring: financial tracking through records/reports, spot checks and audits
  - Service utilization through the DHIS
  - Routine Quality Assessments
  - Plans for deployment of ICT at all levels to improve coordination, tracking and transparency

Discussion questions

- *How have other countries used mechanisms like the Ward Development Committees to strengthen ownership of health programs at the community level?*
- *What are some strategies that other countries have successfully used to build political will and mobilize resources at the subnational level for immunization or PHC?*
- *What are some mechanisms for ensuring accountability over funds at the facility level, including mechanisms for monitoring and measuring progress?*

Help us improve LNCT activities!

Before you go, please fill out a short feedback survey!

We will use this to improve future LNCT activities.

Reported on a scale of 1- Disagree 2- Neither Agree nor Disagree 3- Agree

1. The content of the sessions was relevant to my work and presented in an engaging way.
2. There were opportunities for participants to discuss and share thoughts.
3. There was a good balance between country examples, partner presentations and interactive sessions (Q&A, polls, country work, etc).
4. The collaborative problem-solving session was useful, and I would like to have more sessions like this in future workshops.

Rapporté sur une échelle de 1- En désaccord 2- Ni d'accord ni en désaccord 3- D'accord

1. Le contenu des sessions était pertinent pour mon travail et présenté de manière intéressante.
2. Les participants ont eu l'occasion de discuter et d'échanger leurs points de vue.
3. Il y avait un bon équilibre entre les exemples de pays, les présentations des partenaires et les sessions interactives (questions-réponses, sondages, travail des pays, etc.).
4. La session de résolution collaborative des problèmes a été utile et j'aimerais qu'il y ait plus de sessions comme celle-ci lors des prochains ateliers.

Day 2 wrap-up and closing